

World report on the health of refugees and migrants

Summary



Health for all,
including
refugees and
migrants:
**time to
act now**

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Foreword



Today there are some one billion migrants globally, about one in eight people. The experience of migration is a key determinant of health and well-being, and refugees and migrants remain among the most vulnerable and neglected members of many societies.

This report is the first to offer a global review of health and migration and calls for urgent and concerted action to support refugees and migrants across the world to access health

care services that are sensitive to their needs. It illustrates the pressing need to study and mitigate the root causes of migration and to radically reorient health systems to respond to a world increasingly in motion.

Whether by choice or by force, to be on the move is to be human and is part of human life. Whatever a person's motivation, circumstance, origin or migratory status, we must unequivocally reiterate that health is a human right for all, and that universal health coverage must be inclusive of refugees and migrants.

We live in challenging times. Disease, famine, climate change and war all converge to threaten our global security, putting unprecedented pressures on our societies and economies. Meanwhile, the COVID-19 pandemic continues to have a disproportionate effect on the health and livelihoods of refugees and migrants, with unique challenges for labour migrants.

At the start of 2022, the World Health Organization (WHO) and its partners were responding to complex humanitarian crises in Afghanistan, Ethiopia, Somalia, South Sudan, the Syrian Arab Republic and Yemen, each of which has fuelled mass population movements and severely tested health systems in host countries. Then came war in Ukraine, which pushed the total number of displaced people above 100 million for the first time in history.

But the full extent of the impact of these upheavals is not yet understood because, as this report demonstrates, refugees and migrants are not fully visible in the available data – a serious gap that must be fixed. We must invest in strengthening and implementing policies that promote refugee and migrant health, guided by innovative data gathering and analysis.

We urge governments, agencies, donors and other partners to think creatively and act compassionately to improve the health of people on the move, and to do so across all sectors of society.

I invite you to read this report and join WHO and our partners in our commitment to build a healthier and more resilient world for all.



Dr Tedros Adhanom Ghebreyesus

Director-General

World Health Organization

Preface



Every eighth person on the planet is a migrant or displaced, and the numbers are growing. It is widely accepted that the experiences of displacement and migration are key determinants of health and well-being; consequently, responding to migration is crucial for global health. WHO is fundamentally committed to leaving not one of these people behind. It has, therefore, invested in the gathering and review of global evidence and created this *World report on the health of refugees and migrants*. The report is the first of its kind to illustrate with such breadth and specific detail the multitude of health challenges faced by hundreds of millions of refugees and migrants, drawing on evidence that is as comprehensive as possible from around the globe.

The report presents clear evidence that refugees and migrants can experience poor health outcomes, primarily due to suboptimal working and living conditions, which have a negative impact on the health and well-being of refugees, migrants and asylum seekers, among others. Refugees and migrants often experience much worse health outcomes than host populations, compounded by their vulnerable circumstances and poor health determinants. The report notes just how crucial it is to address the determinants of poor health beyond the health sector when considering the health of refugees and migrants.

Two of the key findings of the report are the virtual absence of comparable data across countries and over time on refugee and migrant health and the lack of disaggregation according to migratory status within global health data sets. The report shows critical gaps globally in data quality and knowledge and calls for investment in fit-for-purpose data, surveillance and monitoring to support robust evidence-informed policies and plans for implementation. If this vital data gap remains, refugees and migrants will continue to be left behind, and achieving the Sustainable Development Goals (SDGs) will be impossible.

Climate change and the increased number of conflicts mean increasing numbers of people are on the move. The impact of anthropogenic climate

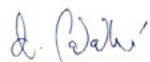
change is already felt across 80% of the world's land area, which holds 85% of the world's population. It is predicted that over 200 million additional people will be forced to move by 2050.

There are solutions. This report offers practical considerations to address health disparities for refugees and migrants and to address the root causes that negatively influence health. These include those that traditionally fall outside the strict remit of the health sector, such as education, sex, age and migratory status. Existing health systems should be reorientated to include refugees and migrants in all services and programmes, in line with the principles of universal primary health care and universal health coverage. The health determinants, status and outcomes of refugees and migrants should be monitored to assess progress, or lack thereof, towards the SDGs and other goals and targets. Because the health and well-being of refugees and migrants cut across multiple sectors of society, the health sector must play an important leadership and facilitating role.

With the magnitude of the challenge so plainly evident and with many promising approaches identified, it is now possible for countries, institutions and researchers to prioritize the actions and investments needed to monitor and improve health and migration in line with the SDGs. WHO's Thirteenth General Programme of Work provides a framework for the urgent action necessary, prioritizing the guiding principles of promoting health, keeping the world safe from disease and focusing on the least-served, most vulnerable populations. These align with the 2030 Agenda for Sustainable Development and its commitment to leave no one behind. WHO's *Global action plan on promoting the health of refugees and migrants* also includes health as an essential component of protection and assistance for refugees and migrants and good migration governance.

The world has rightly responded with national and international policies and frameworks on health and migration, yet substantial disparities remain. What we need now is action, and it will take whole-of-government and whole-of-society approaches to ensure the health of refugees and migrants and their host populations. With this report, WHO and its Health and Migration Programme reiterate a commitment to promoting and advancing the health issues of all refugees and migrants worldwide.

We hope this report will ring the alarm, inspire compassion, increase understanding and, most of all, urge practical action towards universal health care that leaves no one invisible, no one without essential and quality health services, no one behind. Health for all, including refugees and migrants: time to act now.



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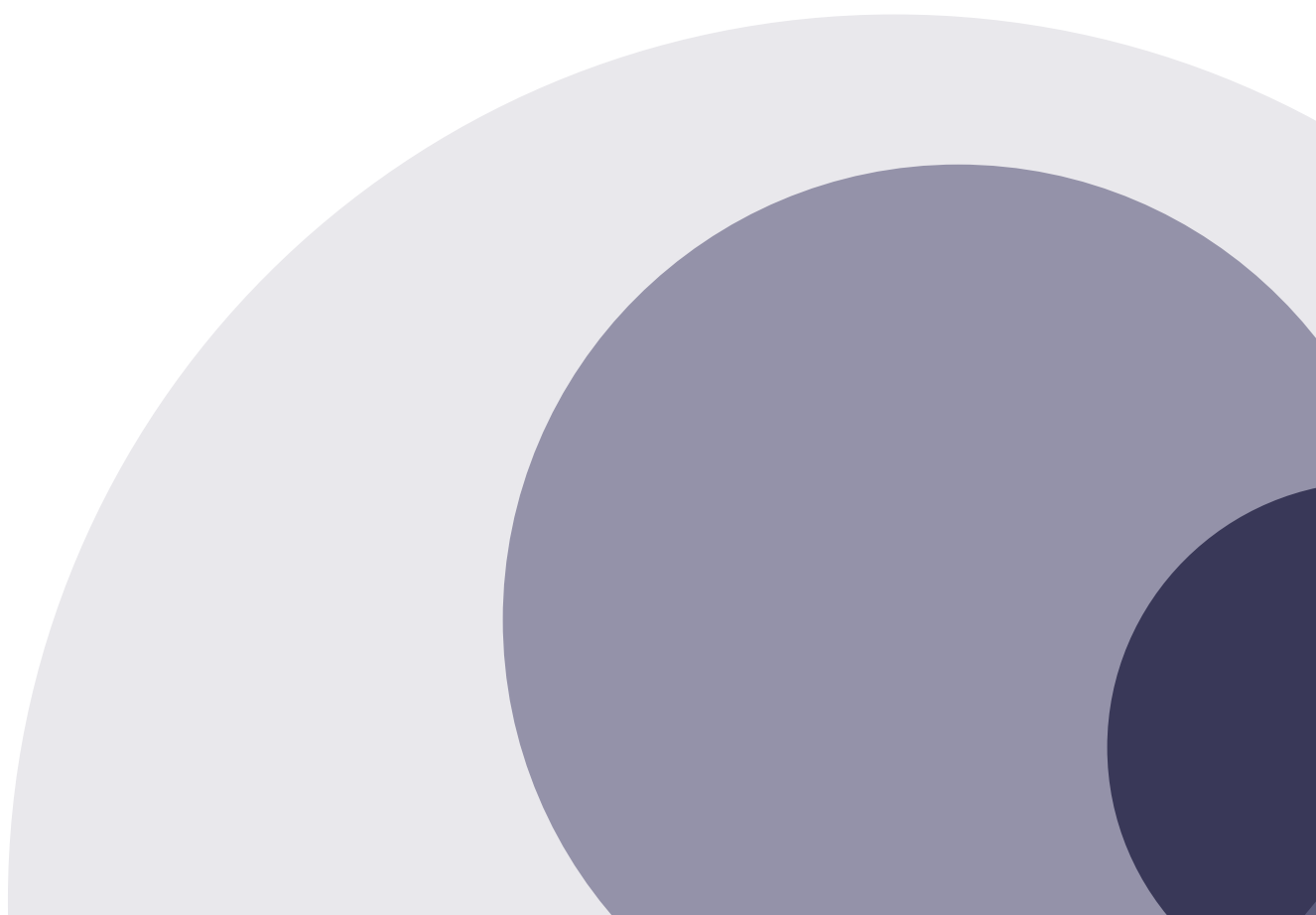
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Abbreviations and acronyms

BADEHOG	Household Survey Data Bank (<i>Banco de Datos de Encuestas de Hogares</i>)
COVID-19	coronavirus disease
DHS	Demographic and Health Survey
GAP	Global action plan on promoting the health of refugees and migrants, 2019–2023 (WHO)
GPW13	Thirteenth General Programme of Work, 2019–2023 (WHO)
IOM	International Organization for Migration
MICS	Multiple Indicator Cluster Survey
SDG	Sustainable Development Goal
TB	tuberculosis
UHC	universal health coverage
UNDESA	United Nations Department of Economic and Social Affairs
WHO	World Health Organization

1. Introduction

In this *World report on the health of refugees and migrants*, the World Health Organization (WHO) brings together key evidence about the multitude of health challenges faced by refugees and migrants along their journeys, and it reveals crucial gaps in global data and knowledge. The report also presents information about good practices and case studies of responses undertaken by governments and other global stakeholders, including refugees and migrants, as well as possible collective responses. Such responses aim to ensure that effective multisectoral research, policy and actions are introduced to improve the health of refugees and migrants. As well as presenting the current global data and evidence on health and migration, the report also outlines current and future opportunities and challenges.

The evidence base for the report includes more than 82 000 documents, from both the scientific literature and grey literature in major languages, including all official WHO languages, and exploration of all relevant and available household surveys, with analyses and reviews by global and regional experts. The scope



A Ugandan refugee and trained yoga instructor, teaches refugees and Kenyans in Kakuma refugee camp alternative ways to maintain their physical and mental well-being. © UNHCR / Samuel Otieno

of this report is limited to refugees and international migrants (referred to as refugees and migrants). The health issues of internal migrants and internally displaced people (those who move or are displaced within countries) will be considered in future reports.

This summary document presents the key findings from the report. Please refer to the complete report for a detailed analysis of the evidence.

1.1 Definitions used in this report

Discussions about how to define migrants are ongoing among practitioners, academics and international organizations dealing with health and migration issues, as well as among experts at the United Nations Statistical Commission, and include consideration of the length of stay and reason for displacement and migration. The terms and definitions most frequently used in this report are described below.

Migrant. A person who moves from one place to another, whether across or within international boundaries.

International migrant. Any person who changes their country of usual residence. Unless otherwise identified, the migrants discussed in this report are international migrants.

Refugee. Any person outside their country of origin who needs international protection because they fear persecution or a serious threat to their life, physical integrity or freedom in their country of origin as a result of persecution, armed conflict, violence or serious public disorder.

Asylum seeker. An individual who seeks international protection. Not every asylum seeker will ultimately be recognized as a refugee, but every recognized refugee is initially an asylum seeker.

International migrant worker. An international migrant who is currently employed or is unemployed and seeking employment in their present country of residence, according to the International Labour Organization's definition.

Migrant in an irregular situation (also irregular migrant, undocumented migrant). A person who moves or has moved across an international border and is not authorized to enter or to stay in that state pursuant to the law of that state and to international agreements to which that state is a party.

For more complete definitions related to refugees and migrants, see the Office of the United Nations High Commissioner for Refugees's master glossary of terms and the International Organization for Migration (IOM) Glossary on migration (1,2).

2. Migration: crucial to global health

The number of international migrants and forcibly displaced individuals reached record levels during the past decade and continues to rise. Displacement and migration are key determinants of health for refugees and migrants, and they also affect the populations of countries along the migratory pathway.

People cross borders for many reasons, from fleeing natural disasters, conflict and a changing climate to seeking economic prospects, cultural experiences and education. These movements are largely predictable and yet, as demonstrated by the impact of the coronavirus disease (COVID-19) pandemic, the world can also be caught unprepared.



In the Colombian municipality of Arauquita, local authorities and humanitarian partners set up shelters and provided aid to people who had recently arrived from Venezuela. © WHO / PAHO / Karen Gonzalez

Refugees and migrants bring much to the places where they move (3). Yet they also have their own health needs, like the rest of a country's population. If ignored, these needs can cost more for refugees and migrants and host countries than if these populations had been included from the outset in national policies and programmes (4). As well as affecting the health of refugees and migrants themselves, displacement and migration may also influence populations in countries along the migratory pathway. Therefore, caring for refugees and migrants is essential to the health of all. Beyond this, few generalizations can be made because migratory patterns vary greatly depending on travel routes and methods, reasons for displacement and migration, and demographics, and these all have an impact on health.

The following notable trends relating to migration and global health offer a helpful frame for this report's key findings.

2.1 Displacement and migration require increased efforts to meet the health needs of refugees and migrants

During the past decade, the number of migrants worldwide almost doubled, with a total of 281 million people on the move worldwide in 2020 (5).¹ While some flows can be predicted by factors such as economic growth and demographic changes, recent history has shown that health emergencies, such as the COVID-19 pandemic, and conflicts can emerge suddenly. Health and social protection systems

need to be prepared for sudden upheaval. Unfortunately, displacement is also on the rise, but it can and should be reduced by rational decision-making at government level.

Increased population movement has profound impacts on health systems in all countries touched by displacement and migration, for both migrant and host populations (Fig. 1). Addressing the health needs of populations on the move is also integral to public health principles and is in line with the right to health for all people living within the borders of a country.

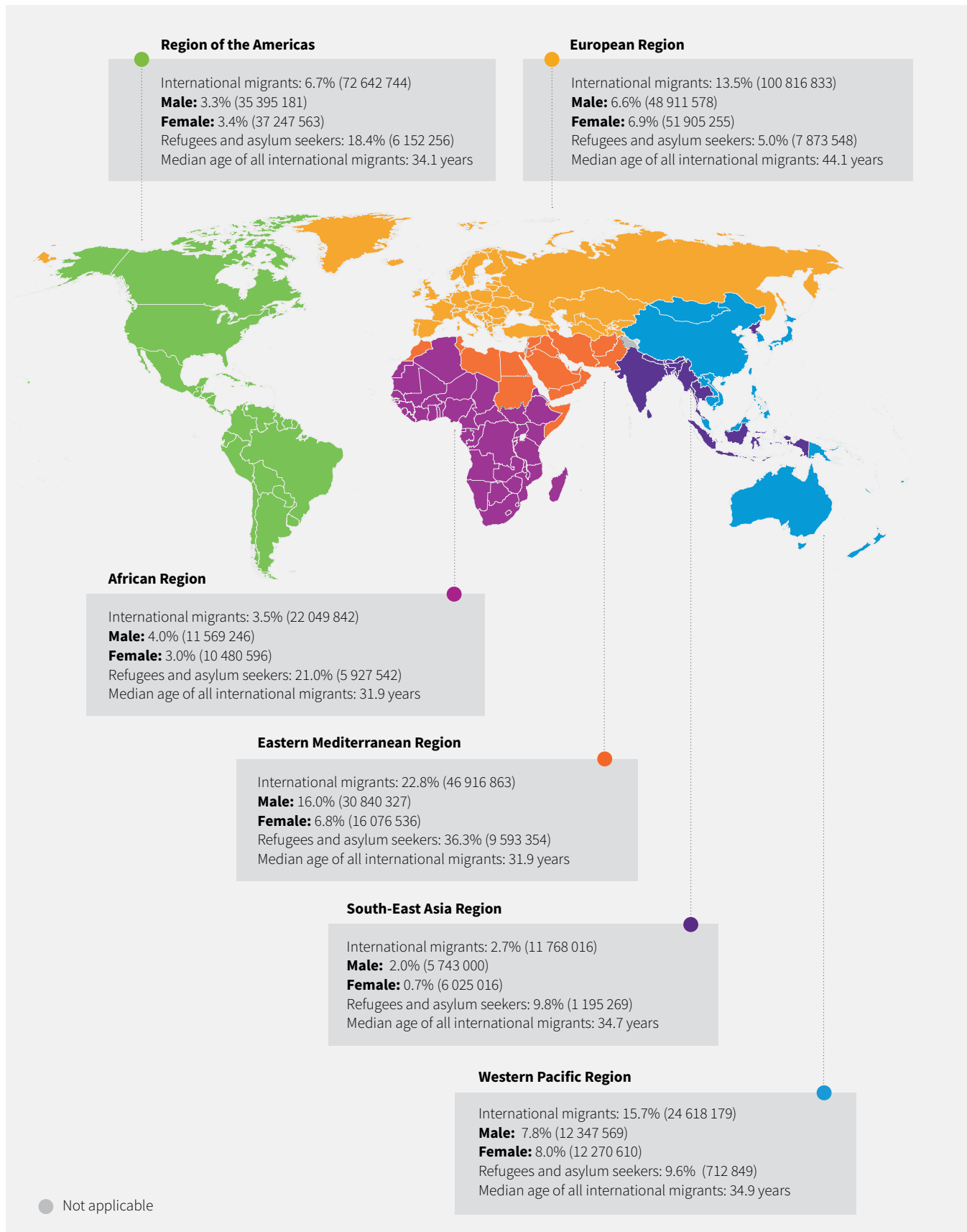
2.2 Health systems are strained by conflict and disasters

Health services in all WHO regions are being strained by the impact of new and renewed conflicts and other disasters. In addition to the deaths of and injuries to both civilians and combatants, the risks of communicable diseases and mental health conditions have risen, and health facilities have been targeted or heavily affected by disruptions to power and supplies. Further downstream, hunger due to disrupted food supplies raises the spectre of starvation and malnutrition. It also decelerates, and in some cases even reverses, progress made towards achieving the Sustainable Development Goals (SDGs).

Refugees and asylum seekers account for approximately 12% of global migrants, and the burden falls disproportionately on low- and middle-income countries who host 86% of the world's refugees (6).

¹ In May 2022, after the writing of this report had been completed, the Office of the United Nations High Commissioner for Refugees reported that the number of people forced to flee conflict, violence, human rights violations and persecution had surpassed 100 million for the first time on record. The number of forcibly displaced people worldwide was already rising towards 90 million by the end of 2021, propelled by new waves of violence or protracted conflict in countries. By May 2022, the war in Ukraine had displaced 8 million people within the country, and more than 6 million refugee movements from Ukraine had been registered.

Fig. 1. International migrants, refugees and asylum seekers (percentage of the total population), by WHO region, mid-2020



A number of other trends and phenomena in the coming decades – from urbanization to growing levels of people smuggling – will influence both migration and the health needs of people on the move. Recent studies suggest that the impact of anthropogenic climate change may already be felt across 80% of the world's land area, which has 85% of the population (7). Climate change can act as a direct driver of migration (e.g. when a natural disaster causes injuries) or an indirect driver (e.g. when environmental changes affect vector-borne diseases). It can also be a risk multiplier by interacting with cultural, social, economic and political factors and compounding their effects: for example, resource scarcity can intensify conflict, reduce economic opportunities and strain public infrastructure.

Refugees and migrants can become productive members in the countries they adopt provided that policies and practices promoting their health are in place.

2.3 Health does not begin or end at countries' borders

While many refugees and migrants are in relatively good health, their numbers also include children and elderly people, people with disabilities, and people whose health has been compromised by their journey or conditions in their country of origin. Others may fall ill in their host country, have children or be injured at work. These health needs cross borders, but many countries limit health coverage by migratory status, so health insurance and health services may be limited and out-of-pocket costs for non-emergency services may be prohibitive.

Refugees and migrants can become productive members in the countries they adopt provided that policies and practices promoting their health are in place. For example, the proportion of migrant doctors employed by health systems in countries in the Organisation for Economic Co-operation and Development has risen during the past two decades: 30% of foreign-born doctors come from lower-middle-income countries and 3–4% from low-income countries (8). Yet policies that separate families, limit access to medical or social services, or condone or promote violence, discrimination or illicit trafficking, yield poor health outcomes. Including refugees and migrants in health services is consistent with the SDGs, global human rights standards and the principle of leaving no one behind.

2.4 Whole-of-government and cross-sectoral responses are essential

Health, displacement and migration are integrally linked to global health, global development and migration governance. At the international level, these global agendas have enshrined addressing the needs of refugees and migrants as strategic areas that are key to achieving policy goals. Numerous frameworks, agreements and resolutions have been forged during the past decade, including two global compacts, one on migrants (9) and the other on refugees (10), multiple World Health Assembly resolutions (2008, 2017, 2018) (11–13), two global consultations on migration and health (2010, 2017) (14,15) and the 2030 Agenda for Sustainable Development (16). Together, these provide the basis to advance policies and promote multisectoral action to include refugees and migrants in policy-making

and implementation, integrate their specific needs, ensure continuity of care within the context of universal health coverage (UHC) during the various phases of the displacement and migration cycle, and protect them from abuse, discrimination and substandard living and working conditions. Similarly, at the national level, whole-of-government approaches are needed, with policies that involve all relevant sectors working in concert with health departments. Such policies in countries of origin, transit and destination can promote the health of people on the move in a variety of ways, thereby ensuring adequate housing, food, medical care, education, equitable treatment and economic opportunities. However, significant resources will be needed to support technical cooperation, galvanize intersectoral action and build evidence platforms to guide action.

2.5 The role of WHO

Since 2019, WHO's activities have been carried out within its Thirteenth General Programme of Work, 2019–2023 (GPW13) (17). The GPW13 framework prioritizes guiding principles that aim to promote health, keep the world safe and serve the vulnerable. The framework re-emphasizes the pledges of the 2030 Agenda for Sustainable Development to leave no one behind, including refugees and migrants (16). GPW13 focuses on the Triple Billion Targets to achieve measurable impacts on people's health at the country level.

Following on from the United Nation's 2016 *New York declaration for refugees and migrants* (18) – which acknowledged specific national commitments adopted by Member States and the priorities and guiding principles necessary to promote the health of refugees and migrants – WHO Member States adopted the *Global action plan on promoting the health of refugees and migrants, 2019–2023* (GAP), at the Seventy-second World Health Assembly in 2019 (19).

3. Beyond the health sector: determinants of refugee and migrant health

While addressing health outcomes is vital, it is also crucial to address the underlying determinants of poor health. The fact that many determinants are not within the direct influence of the health sector suggests a practical course of action: health ministries must take the lead in promulgating whole-of-government and whole-of-society approaches to ensure the health of refugees and migrants.

Health outcomes cannot be understood, much less improved, without understanding the underlying contexts, conditions and enabling determinants that shape them. Addressing these determinants will often be more effective and less expensive than providing treatment and health services when people are already ill.



A family from Honduras, part of a "Migrant Caravan", walks on a road in Guatemala. © UNICEF / Daniele Volpe

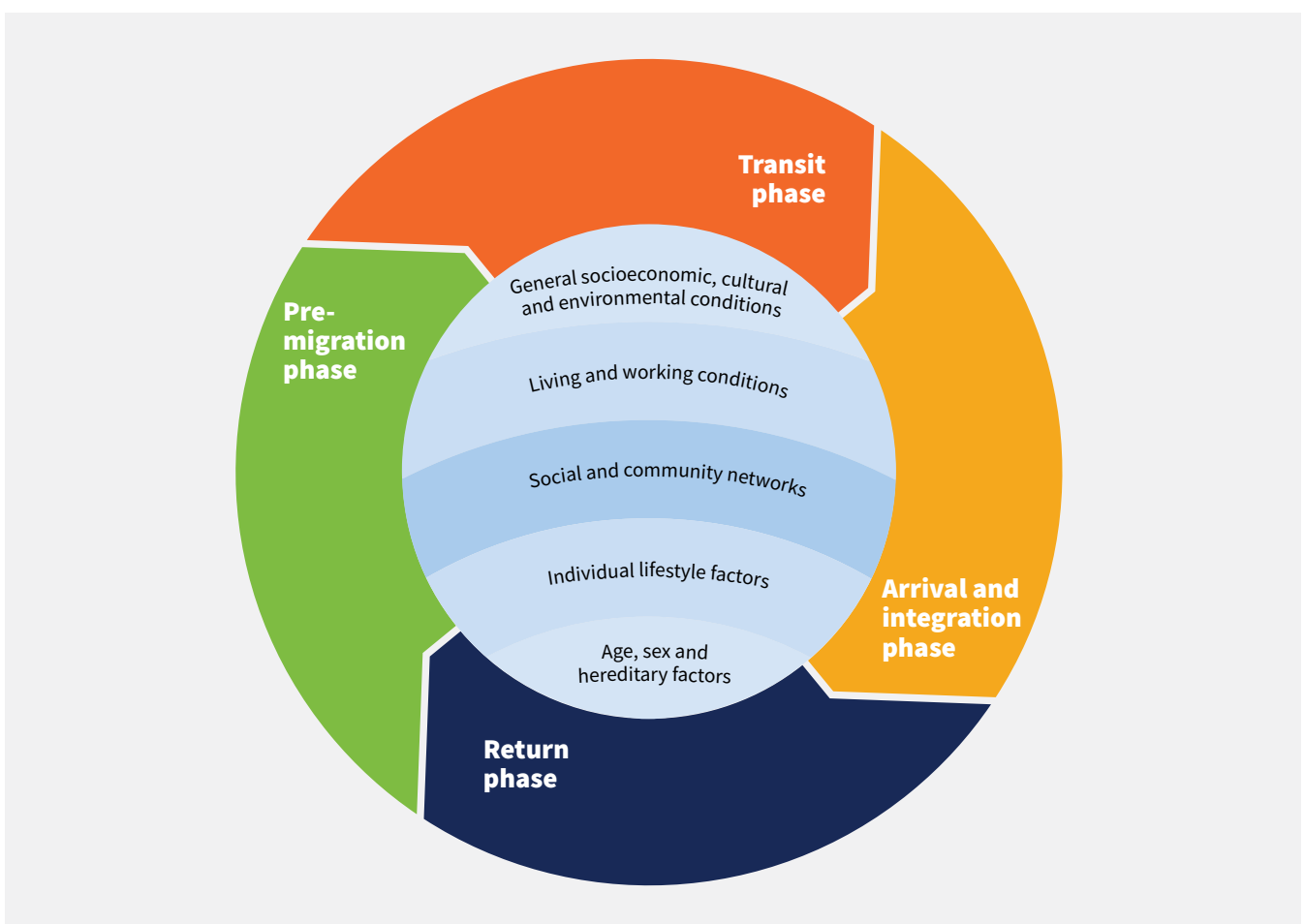
Refugees and migrants are affected by the same health determinants that affect the rest of humanity. However, their migratory status can add a layer of complexity that, when combined with other determinants, makes them particularly vulnerable and affects their health (Fig. 2). Although the categories are fluid and overlapping, WHO classifies these determinants as relating to:

- individual characteristics and behaviours – genetics, gender, personal behaviour and age;
- the social and economic environments – education, health literacy, income and social status, employment and working conditions, social support networks, culture and health services; and

- the physical environment – safe water and clean air; healthy workplaces; safe houses, communities and roads; and food and nutrition.

The experience of displacement and migration is itself a determinant of health, and examining different phases of displacement and migration helps to illuminate its impact.

Fig. 2. Determinants of health and phases of migration



3.1 Individual characteristics and behaviours

The roles, norms and behaviours linked to age and gender shape many of the challenges faced by refugees and migrants of all ages. Threats to good health range from physical, sexual and emotional violence in the household to discrimination and abuses in specific sectors of employment. These factors influence access to health services and how these services respond to the particular needs of refugees and migrants across the life course, including into older ages. For example, women and girls are at greater risk of such threats during various phases of migration. Women have specific needs that require additional services, for example around childbirth, hygiene and physical security. These concerns do not negate the vulnerability of men and boys, but evidence about their vulnerability is limited, often because stigma prevents systematic reporting of sexual violence and support and services for men and boys are inadequate.

Ageing is a factor of ever-increasing importance in global health, with evidence indicating that older refugees and migrants face greater health risks across a variety of determinants. For example, the proportion of people aged 50 years and older in fragile countries, where conflict and disasters are more likely to occur, is projected to increase from 12.3% (219.9 million) in 2020 to 19.2% (586.3 million) in 2050 (21).

3.1.1 Unaccompanied or separated children

One age group that needs to be highlighted is unaccompanied or separated children. They are particularly at risk for physical and sexual violence, and also for developing mental health issues. During transit, these

children, particularly girls, may join families or groups to which they are unrelated for protection; however, these unrelated families or groups may be linked to exploitation and violence. Factors contributing to the high risk of developing mental health issues include forced separation from the child's family, the death of a close family member and a lack of social support. Evidence from the Netherlands indicates that the type of care facility in which unaccompanied or separated children reside influences their mental health: unaccompanied or separated children living in large reception centres had the poorest quality environment and also exhibited the most mental health problems compared with children living in other accommodation, such as small living units or with foster families.

3.2 Social and economic environments

Social and economic determinants disproportionately affect populations that are the most vulnerable. It is these determinants (rather than diseases or medical conditions themselves) that explain most of the poor health outcomes experienced by refugees and migrants. For example, refugees and migrants with lower levels of education often experience poorer physical or mental health outcomes than those with higher levels of education. Displacement and migration often interrupt education, which may be difficult to access or withheld by cultural norms that encourage parents to keep children, especially girls, out of school. Removing such barriers is in the interest of transit and host countries since education and schools also serve a number of other health and social needs, for example, as sites for delivering immunization programmes and community-based nutrition interventions.

Income is another key determinant. In addition to being a barrier to accessing health services, economic insecurity may worsen the physical and mental health of refugees and migrants.

For example, evidence from refugee camps in various parts of the world, highlighted a correlation between lower income and a higher prevalence of chronic diseases. And economic security can have a positive impact on health; for example, access to the labour market and income generation significantly improved the mental health of refugees.

As the use of immigration detention expands worldwide, there is substantial evidence of deaths, suicides and cases of self-harm in these settings, often due to factors such as insanitary conditions and limited health care and also to uncertainty about the future. Some 80 countries detain migrant children, and the annual number of detained children may be as high as 330 000, even though such detention is prohibited by international law (22).

3.3 Physical environment

Living and working conditions often affect the health of refugees and migrants. For example, where migrant workers spend a great deal of time in workplaces or dormitories, overcrowding and inadequate ventilation have been found to contribute to the spread of communicable diseases. Access to safe and secure housing can vary greatly depending on migratory status, which can also determine whether refugees and migrants are included in national policies and programmes or qualify for support from international organizations. Issues as basic as finding safe drinking-water may be a challenge. Food insecurity can also be a major issue, especially among labour migrants, who may adopt harmful coping strategies, such as changing their food habits or skipping meals to send money home.

4. Death, danger and dismal health status

In addition to routine methods for dealing with diseases, a displacement and migration lens is also needed – taking account of the full displacement and migratory cycle of points of origin, transit, arrival and return – and solutions must be tailored to specific target groups.

Around the world, refugees and certain groups of migrants, such as international low-skilled migrant workers, face poorer health outcomes than people in host countries if the conditions in which they live and work are not conducive to good health. If addressed in a timely manner, including making efforts to promote health, diseases can be prevented or treated so they do not



A migrant worker from Myanmar, is vaccinated against COVID-19 in Mae Sot, Thailand, in November 2021. The vaccination campaign, which followed a survey exercise carried out by the Ministry of Public Health, aimed to ensure that migrant workers returning to Thailand were protected against COVID-19 as the country reopened its borders. © WHO / Anat Duangjan

become a burden for refugees and migrants, or their host population, making it easier for refugees and migrants to actively contribute to their countries of origin and destination.

4.1 Death and disappearance

More than 47 296 people died on migration journeys worldwide between 2014 and 2021, according to the IOM Missing Migrants Project. Of these, 20 464 individuals disappeared during sea crossings. Nearly 8000 fatalities have an unknown or mixed cause of death or disappearance (23). These data – which come from a wide range of sources (e.g. coast guards and medical examiners, media reports, nongovernmental organizations, and surveys of and interviews with migrants) – represent a final, tragic indicator of unsafe migration. Most of those who die cannot be properly identified, leaving their families in perpetual uncertainty about their fate.

4.2 The COVID-19 pandemic

COVID-19 has shown, yet again, that if refugees and migrants are not included in national public health strategies – such as those for preparedness and response – their health and that of their host communities cannot be protected and promoted.

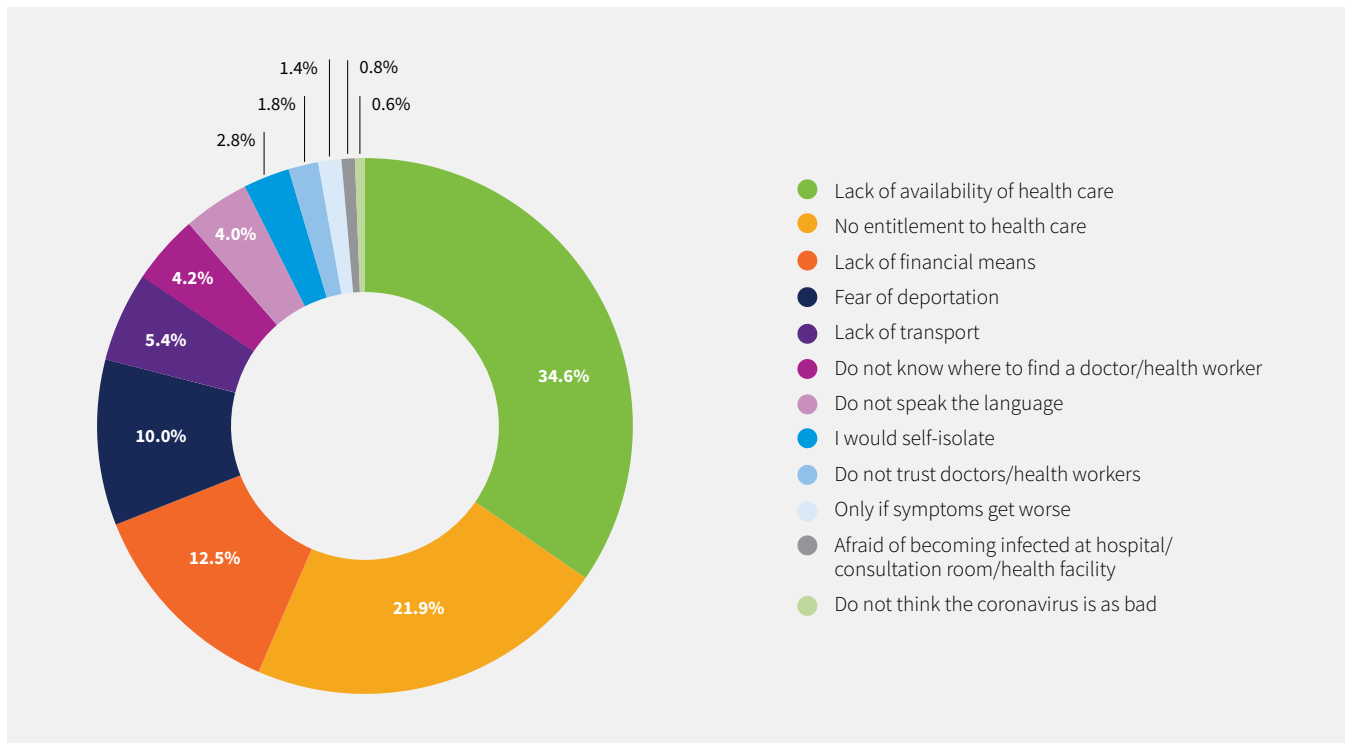
There is evidence that refugees and migrants were disproportionately affected by the COVID-19 pandemic: it increased their burden of disease, reduced their income, affected their social and mental well-being, and reduced their mobility through travel restrictions. The critical sectors in which refugees and migrants tend to work were strongly affected by the pandemic.

Those experiencing crowded work or living conditions were particularly exposed.

A recently published WHO report, developed in collaboration with Ghent University, the University of Copenhagen and the ApartTogether Consortium, was based on a survey of 30 000 refugees and migrants globally; it provided evidence that the COVID-19 pandemic significantly affected their access to work, personal safety and financial means, as well as their social and mental well-being (24). Refugees and migrants living on the streets, those living in insecure accommodation or asylum centres, and irregular migrants reported the worst impacts from the pandemic. These same groups, as well as respondents without any formal education, were also less likely to seek health care for suspected COVID-19 symptoms. The main reasons for not seeking health care were financial constraints (35%) and fear of deportation (22%).

There is also considerable evidence that refugee and migrant women and girls were severely affected in many ways, from their mental health to their ability to earn a livelihood. Some women and girls were made more vulnerable to child marriage and human trafficking due to school closures, job losses and increased livelihood insecurity. Many girls were also not expected to go back to schools after they reopened.

At the same time, there are positive examples of flexibility from countries that included and encouraged refugees and migrants, regardless of their status, to get tested for COVID-19, be vaccinated and seek health care, if needed. There were also examples of national leadership that used the pandemic to expand or improve access to health services for refugees and migrants, beyond those for COVID-19 (Fig. 3).

Fig. 3. Reasons for not seeking medical care in case of suspected COVID-19 symptoms

Source: WHO (24).

4.3 Occupational health

Migrant workers constitute almost two thirds of the world's 281 million migrants (5). Globally, compared with workers in the host population, migrant workers are less likely to use health services and more likely to have had an occupational injury. They often work in what are called 3D jobs – dirty, dangerous and demanding – and in high-risk sectors where the pay is low, conditions are poor, and they face risks to their physical and mental health, including abuse. They are less likely to use health care services for a variety of reasons. Male migrant workers tend to work in sectors where there is a high risk of physical injury and, as a result, usually have higher rates of workplace injury. In some high-income contexts, the prevalence of having at least one occupational injury was 47% among migrants from low- and middle-income countries (25).

4.4 Sexual and reproductive health

Refugees and migrants are often less well served than people in host countries when it comes to sexual and reproductive health: depending on the region and circumstances (e.g. camp settings, irregular migration), they may face high levels of sexual violence, have poor awareness of and low use of contraception, and have unmet family planning needs. Social and cultural factors, such as language barriers, legal status and health literacy, may contribute to undermining sexual and reproductive health, along with a preference for traditional contraceptive methods in some regions.

4.5 Maternal and child health

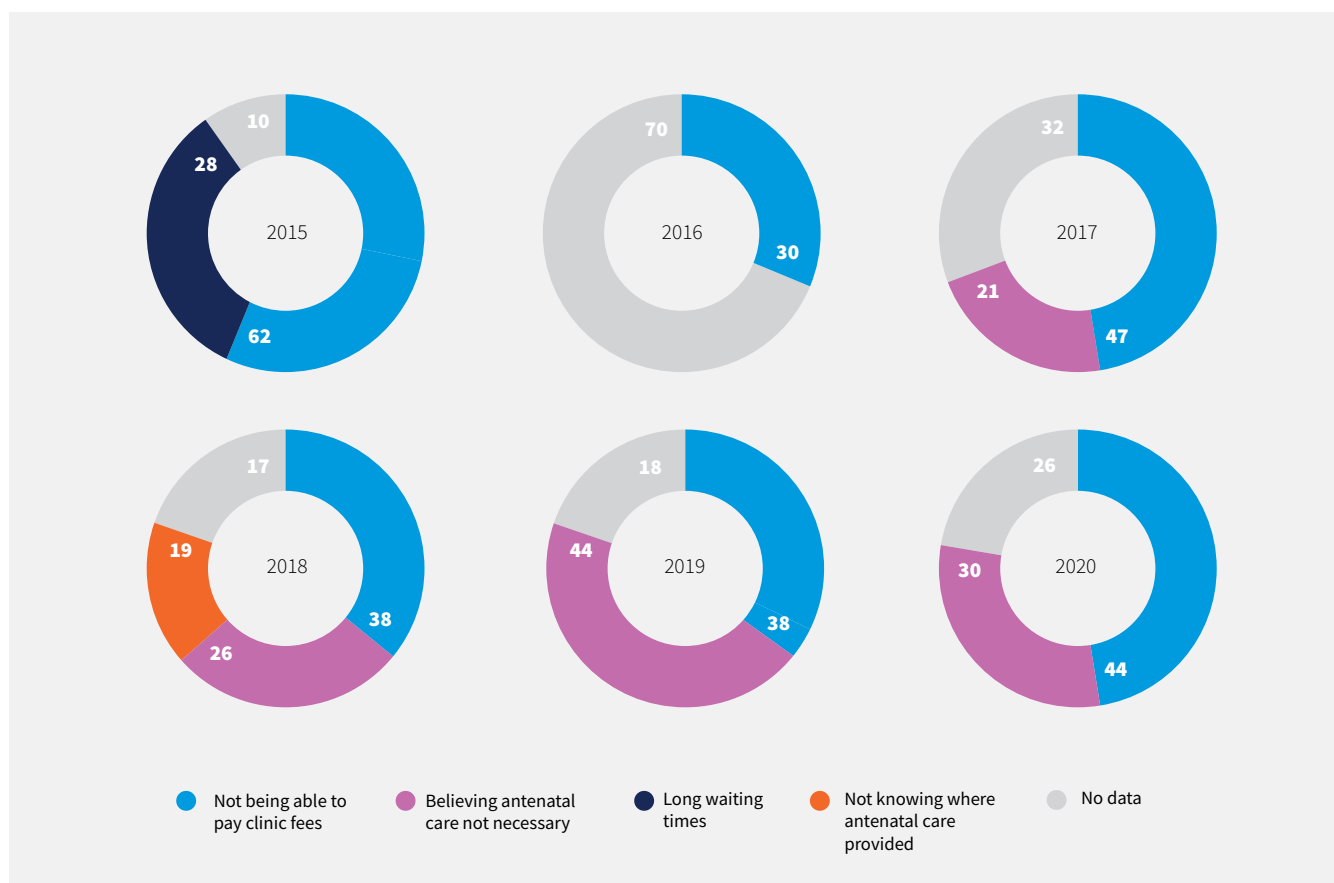
Refugee and migrant women tend to have less access to maternal and child health services than women in their host country. This is particularly acute for access to antenatal care, which is influenced by factors such as migratory status and education level. Evidence shows that refugee and migrant women have a higher risk of negative outcomes during pregnancy and delivery. Access to antenatal care is a key issue in several regions. In the WHO Eastern Mediterranean Region, for example, refugee and migrant women reported attending fewer antenatal care visits than women from the host country. Survey data collected among

Syrian refugees in Lebanon showed that the most common reasons for not accessing antenatal care services were primarily related to payment of the clinic fee, followed by the belief that such services were not necessary (Fig. 4).

4.6 Noncommunicable diseases

As is the case for most populations, refugees and migrants face an increasing burden of noncommunicable diseases, including cardiovascular diseases, hypertension, substance use disorders, nutrition-related health issues, inflammatory diseases and renal diseases. These are often linked

Fig. 4. Most common reasons (%) for not accessing antenatal care services reported by Syrian refugees in Lebanon, 2015–2020



Source: UNHCR (26-31).

to longer residence in the host country, particularly middle- and high-income host countries. Cancer is often diagnosed at later stages among refugees and migrants, who often have lower uptake of or access to preventive measures. Similarly, diabetes and hypertension are undiagnosed longer among some refugees and migrants than among their host population. The WHO African Region has the highest prevalence of hypertension (27%) of all WHO regions, and this is reflected among migrants from there who live in the European Region (32).

4.7 Mental health

Becoming a refugee or migrant may create a number of stresses, and these can have an impact on mental health. In many countries, psychoses are higher among some migrant groups than the general population (33). Causes of stress can include the absence of family or social support, discrimination, ethnic background or the length of time spent in the host country. Recent prevalence estimates by WHO found that the burden of mental disorders is as high as 22.1% in conflict-affected populations (34). Specific populations who have experienced conflict and war, such as younger migrants and adolescents, are more affected by poor mental health. Groups such as refugees and unaccompanied or separated children tend to have a higher prevalence of depression; however, this is highly dependent on their living conditions and the trauma experienced during their displacement.

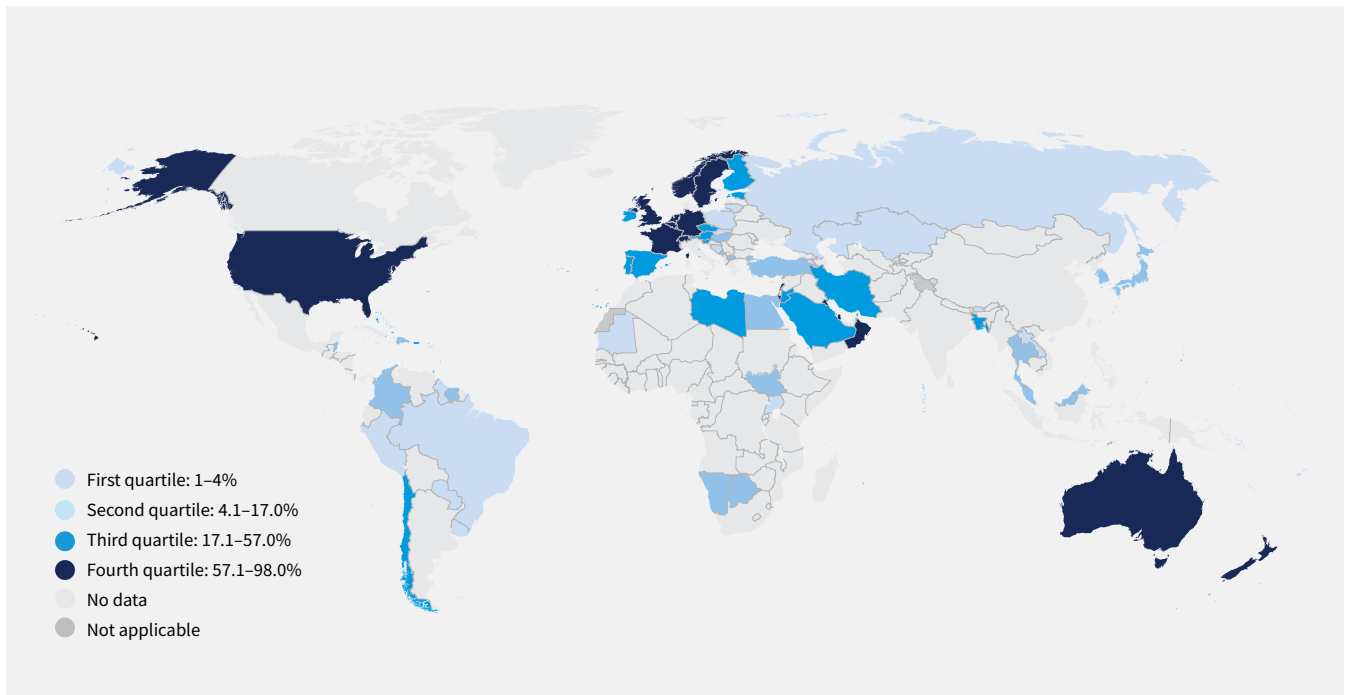
Mental health care for refugees and migrants must be approached holistically, both by providing treatment and by taking into consideration determinants of health, including migratory status.

4.8 Communicable diseases

Evidence does not indicate that refugees and migrants spread diseases in host countries. However, their own susceptibility to infection can be increased by the environmental risk factors related to their living and working conditions. The displacement and migration pathways expose refugee and migrant populations to a number of communicable diseases during transit, on arrival in host countries, or both. Evidence exists that refugees and migrants represent a large proportion of people living with HIV or AIDS in some countries with low prevalences among the host population; yet studies show that a significant proportion of these refugees and migrants acquired their infection after arriving in the host country, indicating a missed opportunity for the health system to prevent spread of the disease.

In high-income settings, where the prevalence of tuberculosis (TB) is low, refugees and migrants account for a higher proportion of people with TB (Fig. 5). Poor living conditions and poverty in general are often associated with many refugee and migrant communities; overcrowded and poorly ventilated living quarters make refugees and migrants more vulnerable to TB. For example, data from refugee camps in Ethiopia indicate that HIV infection is associated with unsuccessful TB treatment. A retrospective study comparing TB treatment outcomes found lower treatment success rates (74.2%) in refugees than among host populations in surrounding communities in Ethiopia (88.1%) (36).

Additionally, displacement and migration can make access and adherence to TB treatment more difficult and can contribute to drug resistance. In some high-income contexts, drug-resistant TB is an emerging concern among refugee and migrant populations.

Fig. 5. Proportion of TB cases among foreign-born individuals, 2020

Source: WHO (35).

This points to the need for ensuring continuity of care throughout the migratory pathway and after migrants reach their destination, as well as addressing poor living and working conditions to prevent new infections and to facilitate access to treatment if a migrant is infected.

Malaria is an emerging concern in low-transmission and non-endemic countries that are also destination countries. There is ongoing intraregional transmission of malaria in the WHO African Region and WHO Region of the Americas. In refugee camps in Ethiopia and Uganda, for example, the transmission of malaria continues to particularly affect young children, especially those who are younger than 5 years. Increasing numbers of Venezuelan migrants in Colombia are seeking health care services for malaria (37–39). These

examples highlight the need for malaria control measures in transit areas and for treatment in the contexts of refugee camps and labour migration. Similarly, various tropical and parasitic diseases that are largely endemic to one or more WHO regions (e.g. hepatitis, leishmaniasis and Chagas disease) are at risk of spreading to other regions if timely diagnosis and treatment are not provided to mobile populations, particularly in destination countries.

5. The case for inclusive health systems

Compared with host populations, for refugees and migrants there may be additional barriers to effectively accessing and utilizing health care services, such as high out-of-pocket payments, language, restrictions on access based on migratory status, and providers who need training to deliver care adapted to their needs. Additionally, the absence of routinely collected data on refugee and migrant health in national health information systems makes it challenging to provide need-based services.

This report looks at the status quo of health systems in various countries and analyses gaps, good practices and leadership through the framework of WHO's six building blocks of health systems: service delivery, the health workforce, access to essential medicines, health information systems, financing, and leadership and governance.



Health education sessions help to promote healthy eating and prevent diabetes in Jordan's Zaatari refugee camp.
© WHO / Tania Habjouqa

5.1 Service delivery

Delivering services to marginalized or vulnerable populations is challenging; in the case of refugees and migrants, they not only face the same barriers as the local population but also may have additional barriers linked to their migratory status. For example, institutional barriers to care include a requirement to show legal documents before services can be accessed and the cost of out-of-pocket expenses. Additionally, restrictive immigration policies have been linked to poor health outcomes for refugees and migrants; across multiple regions, the fear of deportation as a result of accessing health services has been documented as a barrier to access among migrant groups, and especially irregular migrants.

Data collected in 84 countries between 2018 and 2021 show that in half of the countries refugees and migrants have access to all

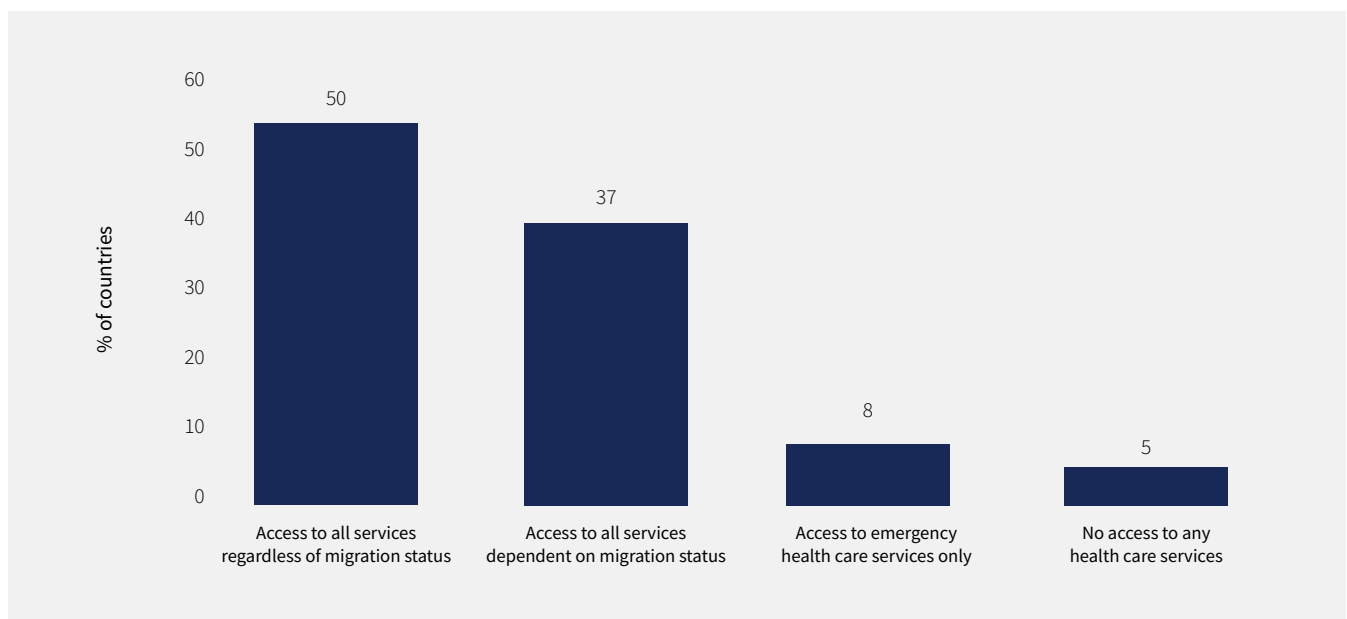
government-funded health services under the same conditions as nationals regardless of their migratory status (Fig. 6).

5.2 The health workforce

In many countries the health workforce is insufficiently trained to deliver refugee- and migrant-sensitive health services. The health workforce must be able to provide culturally competent care and address health issues associated with displacement and migration. Even in high-income countries, there are not enough health professionals with the skills necessary to provide culturally sensitive care to refugees and migrants.

The evidence indicates that making health systems and health care workers sensitive to and knowledgeable about refugee and migrant health is feasible and cost effective, and also benefits host populations. Efforts to strengthen

Fig. 6. Do refugees and migrants have the same status as citizens in accessing government health services? Information from 84 countries, 2018–2021



Source: IOM, unpublished data, 2022.

these capacities, including involving refugees and migrants in health service delivery, are now under way across every region, although resources are often inadequate. In many high-income contexts, migrants form a significant proportion of the host country's health workforce, highlighting the important contributions made by migrants.

5.3 Access to medical products, vaccines and technologies

The report shows that refugees and migrants may have limited access to medication, particularly in refugee camps. This is often due to supply chain difficulties, costs, a lack of adequate diagnostics and medication, and discrimination. As a result, refugees and migrants may resort to self-medication or use non-prescribed medicines or antibiotics; addressing these issues requires building the awareness of possible consequences, such as the potential for antimicrobial resistance, and improving access to care.

Vaccination coverage policies for refugees and migrants vary widely, and vaccine coverage in refugee and migrant populations is low in some cases. Strengthening cross-border vaccination activities and surveillance of seasonal migration could increase vaccination uptake, as could better screening services. Vaccination services should be tailored to the health-seeking behaviours and living contexts of refugees and migrants.

5.4 Health information systems

One of the greatest challenges faced in writing this report was to gather accurate information about the health of refugees and migrants. This is due to an absence of routinely collected epidemiological data (both from general

surveillance and from screening on arrival or at borders), a lack of standardization of data within countries and regions, comparability issues across locations or time of data collection, and an inability to disaggregate data by migratory status. Also, identifying the health needs of refugees and migrants during the reception pathway while respecting their human rights and the right to confidentiality requires effective and efficient data protection policies and screening systems that are integrated with health information systems and linked to health care delivery.

5.5 Financing

Cost is a major barrier to health care access across the regions. Refugees and migrants often cannot afford the out-of-pocket costs of accessing health services. Even when entitled to health services, they often face hidden costs, such as those for transportation or hiring translators, that they cannot afford. As a result, they tend to spend less overall on health services than their host populations. Even when free or subsidized health services exist, evidence shows that many refugees and migrants are not aware of them. Additionally, there is evidence that the cost of excluding refugees and migrants from health coverage is higher than that of including them, a topic that requires more research.

5.6 Leadership and governance

A refugee- and migrant-sensitive health system starts with leadership and governance. When policies are inclusive and support structures exist for implementation and monitoring, efforts to reduce health inequalities among refugees and migrants yield better and faster results. For example, some countries have implemented true UHC and, thus, facilitated



A migrant worker uses a tele-kiosk to speak to a doctor from his dormitory in Singapore. © WHO / Juliana Tan

easier inclusion of refugees and migrants in the coverage. Another clear example is when some countries removed restrictions from health care access so that all refugees and migrants could be tested for COVID-19 and be vaccinated. Not only is it cost effective to ensure that health systems and health care workers are sensitive to and knowledgeable about the health needs of refugees and migrants but it also benefits host populations by strengthening health systems overall.

6. Collect better data

There is a dearth of information and evidence that are comparable across countries and over time. Data on health care for refugees and migrants are of poor quality because they are not disaggregated by clearly defined migratory status, not systematically collected and not representative. While more data are required, it is even more important to ensure that the data collected are of high quality to ensure that no one is left behind.

When Member States adopted the SDGs, they reiterated that these goals would be met only when the needs of all were met. To ensure that the targets are met for all, it is crucial to underscore the importance of the call for disaggregated data in SDG Target 17.18, which is essential to measuring progress.

The original 2020 deadline came and went without much progress. In response, WHO undertook an exploratory review of international survey data about health and migration, the first of its kind. The review was expected to uncover patterns and provide a foundation for monitoring progress towards achieving the SDGs. Instead, it highlighted the inadequacies of the existing data. Data do not yet permit accurate



Two nurses go over patient files in the labour ward of Mama Lucy Kibaki Hospital in Nairobi, Kenya. © WHO / Khadija Farah

Not just more, but better, data

The lack of disaggregated data on refugees and migrants makes it difficult to:

- understand and address their health needs;
- develop inclusive public health approaches for them;
- track progress towards national and global health goals; and
- enable decision-makers to understand and respond to public health challenges that occur within their borders and, therefore, are their responsibility.

measurement of the progress made for refugees and migrants towards achieving the SDG targets.

The review provides both a reminder and a wake-up call for governments; for national, regional and international organizations; and for researchers – practical steps need to be taken urgently if the SDGs are to be met. The review makes two points: more data are needed, but also better and more robust data that are comparable within and across countries and over time. These data should include information about health status, migratory status, and the socioeconomic and environmental determinants of health in which these operate. Only when these data are available will it be possible to accurately assess the health status of refugees and migrants.

While the review does not provide solid baseline data for any specific indicator or target, it does suggest what can be done if comprehensive data are collected systematically in the future.

6.1 Review methodology

The exploratory review considered five large data sets:

- the Demographic and Health Survey (DHS)
- the Multiple Indicator Cluster Survey (MICS)

- the European Social Survey
- the Programme for International Student Assessment
- the Household Survey Data Bank (or BADEHOG, *Banco de Datos de Encuestas de Hogares*).

Countries and surveys were included if:

- data and documentation were available in English
- the reference period was 2015 and later
- the percentage of migrants was at least 1%, required for a meaningful analysis.

While 77 candidate countries had conducted the MICS round 6 and DHS phase VII surveys and posted their data online, only 28 countries fully met the inclusion criteria, had data that could be disaggregated by migratory status and by sex, and, therefore, could be included in the review. (The Annex of the full report provides more information about the methodology used in the report and the review.)

6.2 Results of the review

The review of surveys may have yielded less data than expected, but it succeeded in highlighting the difficulties of and the potential for using household surveys to uncover data on health and migration. None

of the challenges raised by the review are insurmountable, and it is now urgent to undertake a comprehensive review of all data sources. Future reports should consider a variety of data sets, as well as innovative data sources. Only when this is achieved will it be possible to assess where to invest resources and how to move forward on the SDGs and UHC. Key issues raised by the survey review are described in the following sections.

6.2.1 Representative evidence

Refugees and migrants are largely invisible in official data relating to the health SDGs, and even fewer data are available for hard-to-reach populations. The majority of the evidence from the literature reviewed in the report comes from only three of the six WHO regions, and it covers mainly high-income destination countries (Fig. 7). Yet the three remaining regions host a significant proportion of refugees and migrants. This demonstrates the urgent need to support the regions to develop capacities for research and evidence generation.

Although refugees and asylum seekers account for only 12% of individuals who crossed an international border, they account for 34% of those studied in the literature reviewed (Fig. 8) (6). In almost one third of the literature reviewed, there is no indication of which migrant group was studied. Further, in the surveys, the proportion of migrants does not always reflect the actual proportions as reported in the global estimates produced by the United Nations Department of Economic and Social Affairs (UNDESA).

Communicable diseases and mental health were the most commonly studied health issues. While this has produced key evidence in these areas, other health issues, such as noncommunicable diseases and sexual and reproductive health, need to be studied in

a similar manner. This will allow for a more comprehensive analysis of the disease burden on refugees and migrants.

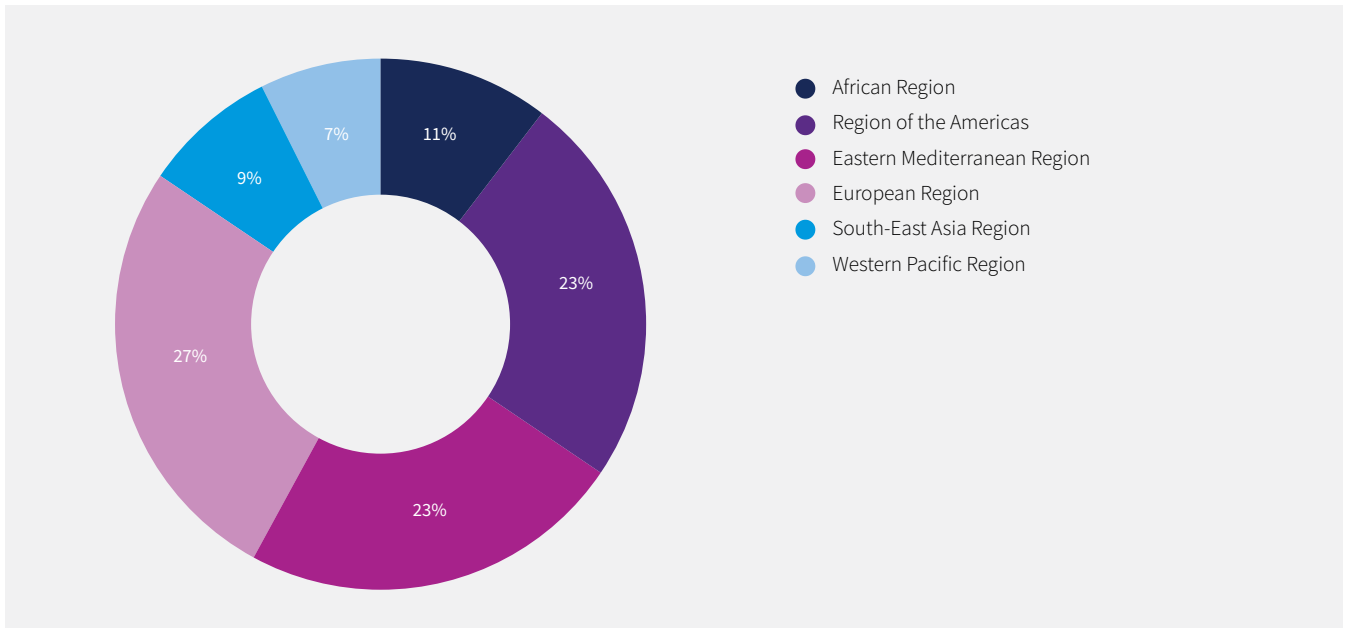
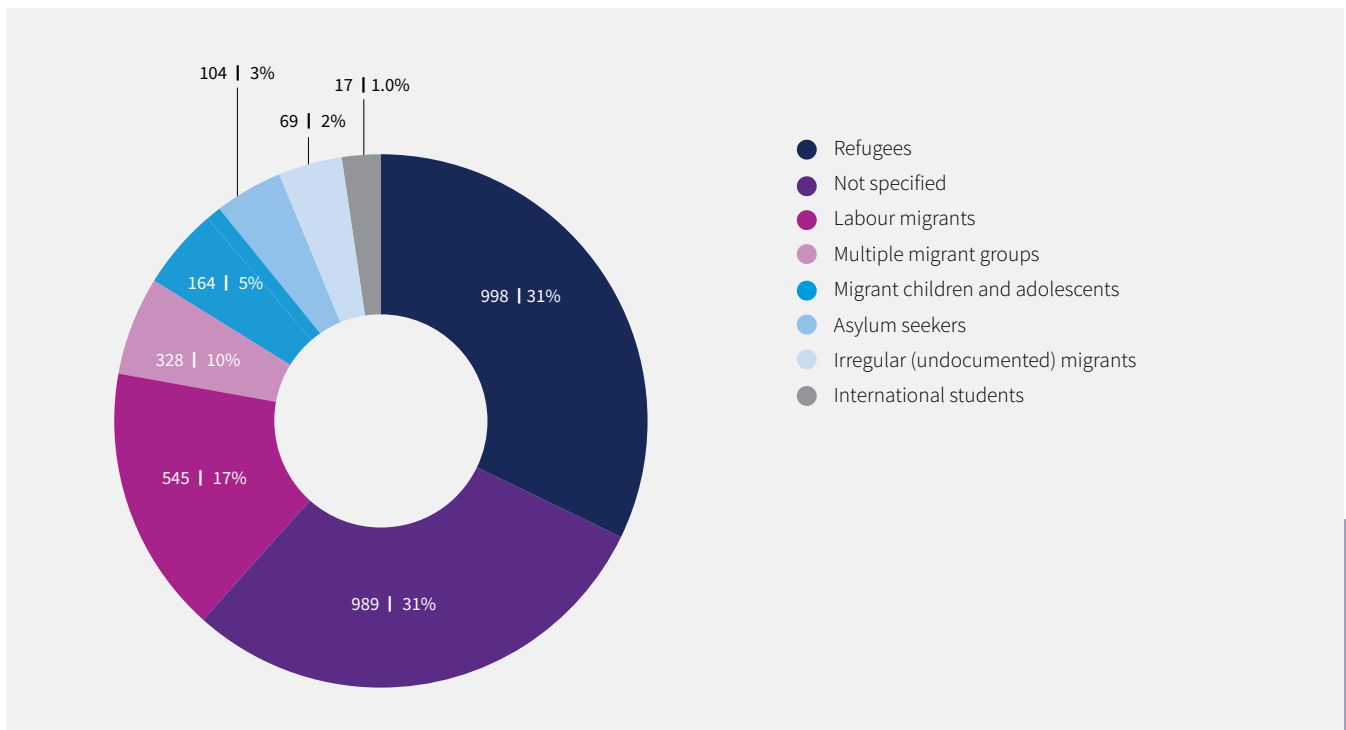
It is crucial that the data used for evidence-informed policy-making are representative of the target population; therefore, efforts to address the skewed nature of the literature are urgently needed.

6.2.2 Sample size

Survey completeness poses another challenge. It is only recently that surveys have started to collect data that specifically track international migration, and such data are not collected in all countries. When the data are collected, surveys may not yield a sample size that is statistically valid and representative of the refugee and migrant populations residing in a country. Statistical validity is even harder to achieve when disaggregating by migratory status and by other factors, such as disability or occupation. The unknowns associated with irregular migration also add an element of difficulty to ensuring that data are complete.

6.2.3 Definition challenges

Identifying a person as a migrant is challenging for global surveys since people on the move may be defined differently by different countries and organizations. While refugee status is clear due to its definition in the 1951 Geneva Convention (40), there is no global consensus on the definition of migrant. The definitions used by IOM and UNDESA provide good examples. IOM's definition is an operational aid for discussing and raising the challenges connected to migration and gathering information; the UNDESA definition is statistical and aims at bringing clarity to data collection and analysis. The questions used by the surveys in the review to identify and define migratory status also vary significantly.

Fig. 7. Proportion of documents included in the review, by WHO region**Fig. 8.** Proportion of documents included in the review, by migrant group studied

7. The way forward

With the magnitude of the challenge so plainly evident and with many promising approaches identified, it is now possible for countries, institutions and researchers to prioritize the actions and investments needed to monitor and improve health and migration, in line with the SDGs. The GPW13 provides a framework for doing so (17).

Implementing inclusive and robust public health systems that conform to the principle of UHC would permit individuals in need of health services to be identified and supported early, before many problems become acute. Until such systems are implemented on a wide scale, targeted efforts will be needed to safeguard and promote the health of refugees and migrants. It is hoped that inclusive and responsive public health systems will be developed in the near future, enabling the global community to consider refugees and migrants as integral parts of a thriving society. This will allow us to move from "refugee and migrant health" to "our health".

7.1 Reorienting health systems for a world in motion: a strategic approach

Health and migration have taken on a new urgency with the GPW13, which prioritizes the guiding principles of promoting health, keeping the world safe from disease and focusing on the least-served, most vulnerable populations. These align with the 2030 Agenda for Sustainable Development and its commitment to leave no one behind (16) and with WHO's five key priorities (41). In order to achieve these priorities, two key approaches are necessary.

7.1.1 Integrating migration into primary health care as the foundation of UHC

UHC has been an integral part of WHO's policy frameworks for several years. WHO's vision now is to facilitate implementation of integrated approaches to health systems to move towards true UHC and health security based on a foundation of primary health care. This drive towards a radical reorientation of health systems, with primary health care as the foundation of UHC, is essential and will not be achieved if refugees and migrants are not included. This strategy is coupled with a shift towards health promotion and disease prevention, made by addressing health determinants and risks; strengthening systems and tools for epidemic and pandemic preparedness and response, supported by reforms in governance and financing; and harnessing the power of science, research innovation, data and digital technologies. WHO's Health and Migration Programme is rooted in these foundational elements.

Such integration requires restoring, expanding and sustaining access to essential health services, especially those focusing on health promotion and disease prevention, and reducing out-of-pocket spending. It also means focusing on the least-served, most vulnerable populations, especially women, children and adolescents, and refugees and migrants. It emphasizes ensuring access to vaccines, medicines, diagnostics, devices and other health products. Finally, on the essential issue of human resources, it urges investment in a health workforce with the training, skills, tools, working environments and fair pay to deliver safe, effective and quality care.

7.1.2 The Global action plan

The SDGs and WHO's GPW13 provide the global context for the GAP (19). The goal of GAP is to assert that health is an essential component of protection and assistance for refugees and migrants, and of good migration governance. More specifically, GAP aims to improve global health by addressing the health and well-being of refugees and migrants inclusively and comprehensively as part of holistic efforts to respond to health needs in any setting. It recognizes that in order to prevent inequities, the public health opportunities and challenges offered by refugees and migrants cannot be separated from those of the host population. This approach is justified not only by humanitarian motivations but also because it reflects rational public health practice.

For a world increasingly in motion, refugee and migrant health is now one of the most urgent public health issues we face. Here are the essential and urgent actions we must work on together for the good of everyone's health.

7.2 Together we can: from policy to practice and actions for a healthy future

The following policy actions aim to both focus the thinking of governments and other stakeholders around the world and encourage them to work together to create essential policies and interventions to ensure there is real progress in the field of health and migration.

1. Develop short- and long-term public health action plans that include refugees and migrants.

Policies relating to health and migration should be built on documented health needs and evidence-based practices and standards. This requires policy coherence among the ministries responsible for a range of sectors that affect the health status of refugees and migrants, not only the health ministry but also the finance, social welfare, labour, immigration, housing and education ministries. Subsequent public health action plans should provide for regular assessments to analyse whether the health system is meeting the needs of refugees and migrants.

2. Strengthen the capacity and increase the sensitivity of health systems to meet the needs of refugees and migrants.

Based partly on experiences gained during the COVID-19 pandemic, WHO has identified three components necessary for implementing an integrated approach to policies addressing migration and public health – that is, by ensuring:

- health protection and access to territories and areas in asylum procedures for people who need international protection;
- flexibility with regard to migratory status in order to ensure that irregular (undocumented) migrants have safe and lawful access to health services; and

- non-discriminatory access to health care that provides equal access to health care for all, regardless of migratory status, nationality, gender, gender identity, age or ethnicity.

3. Enhance understanding of the health promotion and health needs of refugees and migrants.

Advocacy and public health education efforts are necessary to build support for safeguarding and promoting the health of refugees and migrants, as well as for ensuring wide participation in these efforts by refugees and migrants, the public, government and other stakeholders.

4. Actively include refugees and migrants within social protection systems.

Investing in the health of refugees and migrants must take place not only because it is a sound public health strategy but also because health is a basic human right. Since refugees and migrants often face significant social and environmental disadvantages, they should be integrated within social protection arrangements, including social security programmes.

5. Strengthen health information systems by including an accountability framework and indicators.

Policies without evidence are ineffective, while gathering evidence and data without a policy framework is misguided. Therefore, the strategic direction for health and migration policy must be founded on a results framework and supported by strengthened health information systems.

6. Promote global research, strengthen knowledge production and build research capacity in health and migration.

Research is a priority of WHO's Health and Migration Programme, and it is a vital part of filling global evidence gaps on health and migration. The Programme will collaborate with key stakeholders to conduct operational research in the priority areas identified, with the objectives of building research capacity on health and migration at the country, regional and global levels and ensuring that the evidence generated is translated to drive policy and implementation.

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